STATE OF MAINE
BOARD OF DENTAL PRACTICE

In re: Jan B. Kippax, D.M.D.	)	
(Adjudicatory Hearing)	)	DECISION AND ORDER
Case No. 17-21	)	

I. INTRODUCTION

Pursuant to the authority of 32 M.R.S. § 18323(1), and following the procedures of 5 M.R.S. §§ 9051-9064, the Maine Board of Dental Practice ("the Board") met in public session at the Board's offices in Augusta on Friday, October 11, 2019 for a hearing to consider whether grounds exist to impose discipline against the license of Jan B. Kippax, D.M.D., to practice as a dentist in the State of Maine. The Second Revised Notice of Hearing, dated September 25, 2019, required the Board to decide whether grounds existed to impose discipline for:

1. engaging in unprofessional conduct by violating a standard of care that has been established in the practice of dentistry (32 M.R.S. § 18325(1)(E) and Board Rules chapter 9, § II(R));
2. professional incompetence as defined by statute as engaging in conduct that evidences a lack of ability or fitness to perform the duties owed by a dentist to a patient (32 M.R.S. § 18325(1)(D)(1));
3. professional incompetence as defined by statute as engaging in conduct that evidences a lack of knowledge or inability to apply principles or skills to carry out the practice of dentistry (32 M.R.S. § 18325(1)(D)(2)); and
4. failing to retain/maintain complete patient records for a period of no less than 7 years after cessation of a patient's treatment (32 M.R.S. § 18325(1)(E) and Board Rules chapter 9, § II(P)).

Participating and voting Board members were Stephen G. Morse, D.M.D., Board Chair (Dentist Member); Tracey Jowett, R.D.H. (Dental Hygienist Member); Todd Ray, D.M.D. (Dentist Member); M. Lourdes Wellington (Public Member); and Glen S. Davis, D.M.D., Board Vice-Chair (Dentist Member).[1] Licensee Jan B. Kippax, D.M.D., appeared and was represented by James Belleau, Esq., and Adam Lee, Esq. Assistant Attorneys General Andrew Black and Jennifer Archer represented the Board's Staff.[2] F. Mark Terison, Esq.,

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[1] Board members Paul P. Dunbar, D.D.S. (Dentist Member), Nancy Foster, R.D.H., E.F.D.A. (Dental Hygienist Member), and Kathryn A. Young, L.D. (Denturist Member), did not attend the hearing. Board member Mark D. Zajkowski, D.D.S., M.D. (Dentist Member), served as Complaint Officer for the matter. Dr. Zajkowski was in the hearing room, but did not sit with the Board and was recused. Accordingly, none of these Board members took any part in either the Board's deliberations or in its adoption of this Decision and Order. Glen S. Davis, D.M.D., succeeded Stephen G. Morse, D.M.D., as Board Chair during the pendency of this matter.

[2] The Assistant Attorneys General undertook to present evidence on behalf of the Board's Staff, volunteering as the moving party and shouldering the burden of proof by a preponderance concerning the bases alleged in the Second Revised Notice of Hearing for imposing discipline. Jennifer Archer left her position as Assistant

under contract with the Board, presided as independent hearing officer. A quorum of the Board was in attendance during all stages of the proceeding.[3]

Pursuant to 5 M.R.S. § 9063, the hearing officer advised the Board of the necessity of a fair and impartial proceeding, and of the requirement that Board members be free of financial interest, direct or indirect, in the proceeding. The Board members responded negatively on the record concerning the existence of any financial interest in the outcome of the hearing, or any possible bias or prejudice given the subject matter of the hearing and the parties involved, and determined for herself or himself that she or he was capable of making a fair and impartial decision in the matter.[4]

II. MOTION TO DISMISS[5]

The Licensee filed a pre-hearing motion to dismiss that the hearing officer presented to the Board for decision after concluding that he had no statutory or contractual authority to rule upon such dispositive motions. It alleged an intolerable risk of inherent bias in the Board's handling of the complaint, including the activities of Assistant Attorneys General and the Board's administrative Staff, as well as the interactions among the Attorneys, Staff, Complaint Officer and Board. After the Board reviewed the written motion and the Assistant Attorneys General written response to it, the hearing officer advised the Board that its administrative practice enjoys a presumption of honesty and integrity, and that claims of bias or prejudice in its proceedings must overcome that presumption by demonstrating actual bias or prejudgment.

Further, the hearing officer framed the issue for the Board as whether the circumstances reveal that the Assistant Attorneys General, Board Staff or the Complaint

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Attorney General and did not participate in this matter after January 17, 2020.

[3] On the date of hearing, the Board had a full complement of 9 members, and 5 participated and voted. Following the Board's November 8, 2019 decision to re-open its deliberations solely on the matter of sanctions, two Board positions became vacant. By the time of the Board's re-opened deliberations on sanctions on March 13, 2020, those vacancies had not been filled. Of the 7 members serving on the Board, 4 participated and voted on March 13, 2020 on the added sanction provisions and on the Licensee's additional motions to reconsider and to dismiss. Those same 4 Board members also participated and voted on the decisions reached in this matter both on the day of hearing, October 11, 2019, and on November 8, 2019, when the Board voted to re-open its deliberations on sanctions.

[4] Two Board members, Drs. Morse and Ray, revealed that they refer patients to the oral and maxillofacial surgery practice of Killian D. MacCarthy, D.M.D., M.D., whom the hearing officer identified as a potential witness. Both Dr. Morse and Dr. Ray stated on the record that no financial payments or arrangements were involved in their patient referrals. Moreover, both stated that the fact of the referrals would have no impact upon their ability to be fair and impartial in the matter.

[5] Following the Board's decision to re-open deliberations on the matter of sanctions, the Licensee filed a motion to reconsider its decisions reached on October 11, 2019 and later styled it as a motion to dismiss. As a potentially dispositive motion, the hearing officer presented the added motion to dismiss to the Board following the completion of the re-opened deliberations on sanctions on March 13, 2020, along with the motion to reconsider. By motions duly made and seconded, the Board voted 4-0 to deny reconsideration and dismissal.

Officer, given their respective roles as investigators and prosecutors of the disciplinary matter, exercised undue authority, direction or discretion over the Board's ultimate decision on whether to impose discipline. In brief, the hearing officer told the Board that if it concluded that the preliminary proceedings had irretrievably compromised their ability to make a fair and impartial decision based upon the evidence presented at hearing, they should vote to dismiss. If, on the other hand, the Board found that it could follow the independent hearing officer's instructions and make a fair and impartial decision on whether to impose discipline based upon the evidence produced during the hearing--free of the exercise of undue authority by the Assistant Attorneys General or its Staff or Complaint Officer--then the hearing officer advised it should vote to deny the request to dismiss.

Additionally, the hearing officer advised the Board that it could reserve ruling on the motion to dismiss until after it had heard the evidence at hearing. Following public deliberation, and by motion made, seconded, and unanimously approved, the Board voted 5-0 to deny the motion to dismiss.

III. EXHIBITS AND WITNESSES

Without objection, the hearing officer admitted in evidence the Board's Staff exhibits listed below:

1. Second Revised Notice of Hearing dated 9/25/2019
2. ALMS Licensing Data for Jan B. Kippax
3. Complaint from Patient A dated 3/2/2017
4. Response and attached materials from Dr. Kippax dated 5/8/2018
5. Request from Board to Dr. Kippax for missing record dated 3/1/2019
6. Response to Board's request from Dr. Kippax dated 3/4/2019
7. Patient records from CMMC emergency department visit of 7/1/2016
8. Patient records and photos from CMMC Plastic Surgery Office from July 2016
9. Report from CMMC pathology lab dated 7/11/2016 and images of biopsy slide
10. Patient records from Holland Plastic Surgery
11. Photographs of Patient A on 7/1/2016
12. Photographs of Patient A on 7/14/2016
13. Photographs of Patient A on 7/15/2016
14. Photographs of Patient A on 7/28/2016
15. Diagram of Langer's Lines on face
16. Drawings of lips
17. Curriculum Vitae of Killian D. MacCarthy, DMD, MD, FACS
18. Overview of American Association of Dental Boards and its Assessment Services Program [admitted only in the hearing's penalty phase]
19. Copy of relevant statute 32 M.R.S. § 18325(1)
20. Copy of relevant statute Board Rule Chapter 9, § II
21. Principles of Ethics & Code of Professional Conduct [admitted after foundational testimony]

22. Disciplinary Action *In re: Jan B. Kippax, D.M.D.*, No. 01-48, dated 11/8/2002 [admitted only in the hearing's penalty phase]
23. Consent Agreement in *In re: Jan B. Kippax, D.M.D.*, Nos. 02-18, 02-26, 02-33, 02-39, 02-41, 02-45, 02-46, 02-48, 02-49, 02-51, 02-52, 02-54, 02-55, 02-58, 02-59, 02-60, 02-62, 03-17 [admitted only in the hearing's penalty phase]
24. Letter of Guidance issued to Jan B. Kippax, D.M.D., in Complaint Nos. 16-5, 16-6, 16-20, 16-21, 16-22, 16-37, 16-38, 16-39, 16-40, 16-43, 16-45, 16-47, 16-71 [admitted only in the hearing's penalty phase]
26. Dentist Professional Review and Evaluation Program (D-PREP)

Licensee's exhibits were admitted in evidence, without objection, as follows:

9. *Curriculum vitae* of Stuart E. Lieblich, D.M.D.
10. American Association of Oral and Maxillofacial Surgeons Code of Professional Conduct, May 2017
14. Article: Alhamdi A. *Facial Skin Lines.* Iraqui JMS 2015; Vol. 13(2): 103-7

Witnesses who gave sworn testimony were the Licensee, Dr. Jan B. Kippax; an individual who provided her identity to the Board, but who is identified in this Decision and Order only as Patient A; Killian D. MacCarthy, D.M.D., M.D.; and Stuart E. Lieblich, D.M.D.[6] Following the sworn testimony of the witnesses, the Board heard closing arguments and thereafter deliberated, made factual findings, and reached conclusions of law.

IV. FINDINGS OF FACT

Based upon the credible testimony of witnesses, along with documentary evidence and reasonable inferences drawn after a 14-hour hearing, the Board found that the record established the following facts:

A.

Patient A, a board-certified doctor of audiology, was struck in the face with a child's stuffed toy and experienced what she described as a small bump on the right side of her bottom lip that was neither growing nor shrinking in size. She consulted her primary care provider who referred her to the Licensee, a practicing dentist at The Implant Center at Androscoggin Oral & Maxillofacial Surgeons, P.A. At 11:15 a.m. on July 1, 2016, approximately six weeks following the injury, Patient A met with the Licensee, who

[6] The Licensee sought to call four additional witnesses--the Board's Executive Director and Executive Secretary, and the two Assistant Attorneys General presenting evidence in the case--for the purpose of developing the record with respect to the impact of the witnesses' acts, advice to the Board, and exercise of professional judgment upon the claim of risk of bias or prejudgment as alleged in the motion to dismiss. Although the hearing officer excluded the proposed testimony, the Licensee was permitted to preserve the matter in the administrative record for later review through the filing of offers of proof of what he expected the testimony to establish.

confirmed she had a mucocele[7] that would be very simple to remove with a small incision likely requiring no more than four sutures. He assured her that it was likely benign, but as a precaution he would send it to pathology for analysis. Patient A remembered that once she gave verbal consent to proceed with the surgery, the Licensee administered local anesthesia.

An assistant then presented her with a written consent form to review and sign. Although Patient A signed the form consenting to an excisional biopsy of the right lower lip, she recalled that the Licensee had said nothing to her about removing any margin of tissue surrounding the mucocele. Neither did he mention possible disfigurement of her lip, nor a possible loss of vertical height of the lip that could leave her teeth visible with the lips closed. He said nothing concerning possible negative cosmetic consequences attendant to the surgery or that she may need to undergo plastic surgery following excision of the mucocele. Had these consequences been identified and explained, she would not have elected to have the surgery that day, but would have sought a second opinion or consulted a plastic surgeon.

The consent form included the statement, "If my doctor finds a different condition than expected and feels that a different surgery or more surgery needs to be done, I agree to have it done." However, Patient A refused to place her initials in the space provided for her acceptance of and consent to the statement. This was because she wanted to be sure that the surgery would be done as the simple procedure the Licensee had explained to her. Above Patient A's signature, the form stated, "I understand that my doctor can't promise that everything will be perfect. I have read and understand the above and give my consent to surgery."

Also following the local anesthesia, another assistant informed her that she needed to pay for the procedure in full before the surgery could proceed, although Patient A had already provided information about her dental insurance coverage. The assistant added that if insurance later provided payment, then the patient would be reimbursed. According to Patient A, "I was already numb, so I gave the assistant my debit card."

Given the Licensee's description of the procedure, Patient A understood that it would take ten to fifteen minutes and two to four stitches. However, the patient recalled the smell of burning skin as the Licensee cauterized the area, and as the procedure wore on the Licensee commented that mucoceles can grow large if left unattended to, adding that the patient had "done the right thing to come in" for the surgery. Patient A had the feeling that the conversation was "artificial," and "designed to make me feel better due to the long time" the surgery was taking. Still, the Licensee said nothing to her about size of the mucocele being larger than anticipated, and nothing about taking tissue at its margin.

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[7] The Licensee testified that mucoceles are "salivary retention phenomena" in which the outflow duct of the salivary gland is damaged or pinched and then expands like a water balloon as saliva is produced. He stated that mucoceles are generally benign, with "a 5% chance of being something else," and he sees them in patients "a couple of times a year." Although a mucocele can "significantly displace" adjacent tissue, it is unlike a growth because there is "no attachment" to surrounding tissue. Therefore, the Licensee conceded, a mucocele poses no harm to a patient.

After the Licensee removed the mucocele, Patient A counted the number of stitches taken to close the wound. She lost count at sixteen, and began wondering about what had happened to the very simple procedure the Licensee had described. At that time the Licensee informed her that the mucocele had been larger than anticipated, and consequently there would be "slight disfiguring." As he handed her a mirror, the Licensee remarked that "plastics can do magic now." Looking in the mirror, Patient A "saw that a quarter to a third of my lip was missing," the pink part of the lip in the area was "almost all gone," and her teeth were visible with her lips closed. The Patient testified that she "broke down sobbing" and "cried for fifteen to twenty minutes." She was eventually given a prescription for pain and an antibiotic to avoid infection, and told to keep the area clean. After being "escorted out the back door," Patient A called her husband from her car. He met her in the parking lot, and drove her to the pharmacy and picked up her prescriptions so she would not have to go out in public.

Photographs taken at home documented Patient A's appearance. Swelling became so great that afternoon that she and her husband decided to go to the hospital emergency room. Her appearance prompted an emergency room worker to ask if a dog had attacked her. The emergency room physician referred her to a plastic surgeon, and advised her to continue following the Licensee's post-surgical instructions. She saw plastic surgeon Sarah Holland, M.D., on July 5, 2016. Dr. Holland advised her to wait for the wound to heal, but that revision surgery may be required. Patient A kept follow-up appointments with the Licensee on July 15, 2016 and July 29, 2016. Patient A recalled that the Licensee did not make the referral to the plastic surgeon until the second follow-up appointment.

Patient A returned to Dr. Holland in August 2016 with "a pretty thick scar on the mucosal surface of the right lower lip as well as a deficient dry vermilion." Dr. Holland recommended scar massage two to three times per day for the next six months.
When Patient A became aware of other complaints against the Licensee, she emailed a complaint to the Board in March 2017.

Patient A consulted Dr. Holland again in October 2017. Notes from the visit documented a "1 x 1 cm defect in dry and wet vermilion right lower lip." Tissue loss was "through and through." Dr. Holland wrote: "Lower teeth are visible through defect at rest." Planned treatment was "V wedge incision of deformed area" with the aim of "restoring normal lip contour." This was because the Licensee's mucocele excision "left her with a large divot of the right lower lip that prevented oral competence in that area." The surgery took place in December 2017, when a V-wedge incision was "taken down to the apex of the mental cleft" to perform a "7 cm complex repair ... including muscle, mucosa, deep dermis and skin."

B.

First licensed to practice dentistry in Maine in 1985, the Licensee became certified in 1991 as an oral and maxillofacial surgeon. He testified that he recommends removal of mucoceles, along with the damaged salivary gland, so as to avoid a recurrence. According to the Licensee's testimony, it is best to remove a mucocele intact and without puncturing it.

This is because a puncture results in losing the precise location of the lesion and also increases the risk of infection of surrounding tissue. For an excisional biopsy, the Licensee takes "a margin of safety" of one to three millimeters of surrounding tissue, but tries to minimize the margin for lesions that are likely benign.

The Licensee did not recall talking to Patient A about the risk of disfigurement of her lip, that vertical height of the lip could be lost, or that additional plastic surgery may be needed. He had no memory of whether he told her that after the surgery her teeth could still be visible with her lips closed. The Licensee acknowledged that the written consent for the biopsy procedure did not identify these risks.

Also, the Licensee had no recollection of the particulars of the surgery, but relied upon his usual practice and his operative note form. The form for the excisional biopsy of Patient A's mucocele reflected administration of local anesthesia and cautery. With the positive sign circled for hemostasis, and the negative for complications, the note contained a hand-drawn set of lips with an oval representing a lesion at the right side of the lower lip, and with "1.5 x 1.5 cm" written nearby. Although a checkmark appeared on the form in the space beside "See Dictated Note," the Licensee searched for the dictated note, but could not find it when the Board requested it. He testified:

> My recollection now is that I have no knowledge of another note and I cannot produce one. I don't know what to say to that checkmark. Sometimes I did dictated notes. Sometimes I did not. Possibly I checked it, but then decided against it. I really don't know.

The Licensee did not remember whether he used cautery to make the incision, but asserted, "Usually I use cautery on mucoceles." He insisted that a large defect was a realistic consequence given the size of the mucocele. Moreover, he testified, "you don't know the size until you get into it." The Licensee had no memory of closing the wound or the number of sutures used. He did not record the number because the sutures were dissolvable. At the conclusion of the surgery the Licensee prepared a routine surgical pathology laboratory order form showing that he had collected an intact raised lesion from the right lower lip of Patient A at 12:30 p.m. on July 1, 2016, by excisional biopsy, and measuring 1.5 x 1.5 cm. He recorded his impression on the form that the lesion was a mucocele that resulted from "hit in face by child's toy." The pathology report confirmed that the submitted specimen was "a mucosal biopsy measuring 1.7 cm x 1.3 cm x 1 cm with a simple dome shaped lesion" consisting of a mucocele negative for malignancy.

Shown a photograph of Patient A taken at home on the day of surgery, the Licensee testified, "I don't remember seeing anything like this." Neither did he remember giving a mirror to Patient A, or her reaction immediately after the surgery. Had she been "really upset," the Licensee said, "I would have remembered and documented it." He stated, "I have no recollection of her breaking down." Further, the Licensee asserted that the surgery was "done well," his work for Patient A was "solid," and if he had the chance he would do the procedure the same way.

A "night call" note from the Licensee's assistant the day after the biopsy revealed that Patient A "report[ed] feeling a little sore (around a three) and . . . some numbness." The note reflected that the patient planned to take the week off from work and to report back for a recheck. The follow-up visit occurred on July 15, 2016, when the Licensee testified that he first noticed the loss of the lower lip's vertical height. He wrote that Patient A was "healing well" with "no sign of any infection on the lower lip." The Licensee added: "it does look like there will be a defect in the lower lip because of the size of the mucocele that was removed from here." Further, the Licensee referred her to a plastic surgeon "for evaluation and treatment to improve on the defect in this area." Finally, he wanted to see Patient A again for a second follow-up appointment in ten days.

C.

Killian D. MacCarthy, D.M.D. (University of Connecticut School of Dental Medicine, 2001), M.D. (Harvard Medical School, 2004), certified by the American Board of Oral and Maxillofacial Surgery since 2009, and practicing in South Portland, Maine since 2007, testified as an expert, and was paid $100 per hour for his services in the case. Referring to the photographs of Patient A taken at home on July 1, 2016, Dr. MacCarthy stated that "an ordinary and prudent oral surgeon would have immediately recognized a significant defect" upon the completion of Patient A's surgery. Moreover, he had never seen any individual need to undergo the type of reconstructive surgery after removal of a mucocele that was required for Patient A. In Dr. MacCarthy's opinion, the removal of tissue with the resulting volume defect or disfigurement that Patient A experienced is usually reserved for a patient with a malignancy. His opinion was that an ordinary and prudent oral surgeon in Maine would remove a mucocele without causing the tissue volume defect of Patient A, and that Patient A should not have needed the reconstructive surgery that she required following the Licensee's excision of the mucocele. In short, Dr. MacCarthy testified that the Licensee violated the standard of care required of the ordinary and prudent oral surgeon in Maine.

D.

Stuart E. Lieblich, D.M.D. (University of Pennsylvania School of Dental Medicine, 1981), certified by the American Board of Oral and Maxillofacial Surgery since 1986, and practicing in Avon, Connecticut, also testified as an expert, and received $5,000 for his services in the case. Dr. Lieblich has never practiced in Maine. He stated that a mucocele may cause necrosis in surrounding tissue from pressure as it increases in size, and that the volume and depth of a mucocele are "hard to know before surgery." In Dr. Lieblich's view, removing a 2 mm margin around a mucocele is a "limited amount of excision," and one would hope the defect would not be substantial. Dr. Lieblich described the outcome of Patient A's surgery as "unexpected" and "very unusual." He conceded that in the 300 or 400 mucocele removal procedures he had done, he had never had a patient whose lip was disfigured during the surgery. However, he stated that a bad result does not mean that the Licensee deviated from the standard of care. In Dr. Lieblich's opinion, the Licensee did not engage in unprofessional conduct, or demonstrate professional incompetence either by lack

of ability or fitness to perform duties owed to a patient, or by lack of knowledge or inability to apply principles or skills to carry out dental practice. Dr. Lieblich testified that proper office practice did not require a dictated surgical note, and the Licensee's operative note form was adequate to meet the standard of care. According to Dr. Lieblich, the need for Patient A to undergo revision surgery was due to the size of the mucocele, and not to any deviation from the standard of care.

V. GOVERNING STATUTES AND RULES

The purpose of the Board is to protect the public health and welfare, and the Board satisfies its purpose by ensuring that competent and honest practitioners serve the public. *See* 32 M.R.S. § 18321(1). Pursuant to 32 M.R.S. § 18325(1), the Board is authorized to "suspend, revoke, refuse to issue or renew a license . . ." Grounds for taking such action include engaging in unprofessional conduct by violating a standard of professional behavior or care that has been established in the practice of dentistry. *See* 32 M.R.S. § 18325(1)(E); Board Rules Chapter 9, § II(R).

Further, the Board may impose discipline for professional incompetence as defined by statute as either engaging in conduct that evidences a lack of ability or fitness to perform the duties owed by a dentist to a patient, or evidences a lack of knowledge or inability to apply principles or skills to carry out the practice of dentistry. *See* 32 M.R.S. § 18325(1)(D)(1) and (2). The Board may also impose discipline upon licensees who fail to retain or maintain complete patient records for a period of no less than 7 years after cessation of a patient's treatment. *See* 32 M.R.S. § 18325(1)(E); Board Rules Chapter 9, § II(P).

VI. CONCLUSIONS OF LAW

After presentation of evidence and arguments, the Board discussed the grounds alleged for disciplinary action in the Second Revised Notice of Hearing, and based upon the evidence recounted above and otherwise appearing in the record of the hearing but not specifically mentioned in this Decision and Order, reached the following conclusions by a preponderance:

By motion made, seconded, and adopted upon a vote of 4-1, the Board found that the Licensee engaged in unprofessional conduct by violating a standard of care that has been established in the practice of dentistry, in violation of 32 M.R.S. § 18325(1)(E) and Board Rules Chapter 9, § II(R).

By motion made, seconded, and adopted unanimously upon a vote of 5-0, the Board found that the Licensee was professionally incompetent for engaging in conduct that evidences a lack of ability or fitness to perform the duties owed by a dentist to a patient, in violation of 32 M.R.S. § 18325(1)(D)(1).

By motion made, seconded, and adopted unanimously upon a vote of 5-0, the Board found that the Licensee was professionally incompetent for engaging in conduct that evidences a lack of knowledge or inability to apply principles or skills to carry out the practice of dentistry, in violation of 32 M.R.S. § 18325(1)(D)(2).

Additionally, and by motion made, seconded, and adopted unanimously upon a vote of 5-0, the Board found that the evidence did not establish by a preponderance that the Licensee failed to retain or maintain complete patient records for a period of no less than 7 years after cessation of a patient's treatment, in violation of 32 M.R.S. § 18325(1)(E) and Board Rules Chapter 9, § II(P).

VII. DISCIPLINARY SANCTIONS

After additional discussion, and by motion made, seconded, and adopted upon a vote of 4-0, with one member abstaining, the Board imposed the following disciplinary sanctions:

1. the Licensee is hereby REPRIMANDED;
2. the Licensee is placed on probation for a period of five (5) years, with the following condition: the Licensee must complete continuing education consisting of three (3) course hours in patient communication and six (6) course hours in oral pathology, pre-approved by the Board, within twelve (12) months of the date of this Decision and Order, and continuing biennially thereafter, all in addition to the continuing education hours required for renewal of licensure.

After voting on November 8, 2019 to re-open deliberations solely on the matter of sanctions, and after additional deliberations duly noticed and held on March 13, 2020, and by motion made, seconded and adopted upon a vote of 4-0, with the prior abstaining member absent and not participating, the Board imposed the following additional disciplinary sanctions:

3. the Licensee shall pay the costs of hearing, in an amount not to exceed $6,000, with 12 months of the date of this Decision and Order; and
4. the Licensee shall undergo a behavioral assessment by the Maine Medical Professionals Health Program, to be completed within 90 days of the date of this Decision and Order.[8]

Dated: 3/13/2020

Glen S. Davis, D.M.D., Chair
Maine Board of Dental Practice

[8] In adopting the added sanctions on March 13, 2020, the Board's deliberations cited its fatigue after a long day of hearing on October 11, 2019, its obligation to protect the public, along with the Licensee's "lack of empathy for the patient," as well as "how [the Licensee] handled the situation."

Appeal Rights

Pursuant to the provisions of 5 M.R.S. §§ 11001-11002 and the general language following 10 M.R.S. § 8003 (5)(G), any party that appeals this Decision and Order must file a Petition for Review in the Maine Superior Court having jurisdiction within 30 days of receipt of this Decision and Order. The petition shall specify the person seeking review, the manner in which the person is aggrieved, and the final agency action which the person seeks reviewed. It shall also contain a concise statement as to the nature of the action or inaction to be reviewed, the grounds upon which relief is sought, and a demand for relief. Copies of the Petition for review shall be served by Certified Mail, Return Receipt Requested, upon the Maine Board of Dental Practice, all parties to the agency proceedings, and the Maine Attorney General.